STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155148	B. WING		02/28/2012	
NAME OF I	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
NORTH	PARK NURSING (CENTER	650 FAIRWAY DR EVANSVILLE, IN 47710			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE	
1 0000						
F0000	Complaints INO IN00104314. Complaint IN00 Federal/state de allegations are of F315, F465 and Complaint IN00 Federal/state de allegations are of Unrelated deficil Survey dates: F2012 Facility number Provider number AIM number: Interest and INO	20103856 - Substantiated. Ifficiencies related to the cited at F253, F312, F314, d F514. 20104314 - Substantiated. Ifficiencies related to the cited at F314 and F514. Itencies cited. February 26, 27, and 28, The color of the cited at F3148 and F5148. Itencies cited. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F3148. The color of the cited at F3148 and F31	F0000	The creation and submission this Plan of Correction does reconstitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credict Allegation and requests a De Review in lieu of an on-site vion or after March 16, 2012. Neark Nursing and Rehabilitation Center 650 Fairway Drive Evansville, Indiana 47710 Telephone: 812-425-5243 Respectfully, Kathleen Bodecker Executive Director	not is is is it on of lible sk isit orth	
	Medicaid: 70					
1				I		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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7U2B11

Facility ID:

000069

TITLE

PRINTED: 04/05/2012 FORM APPROVED OMB NO. 0938-0391

		DENTIFICATION NUMBER: 155148	A. BUILDING B. WING	00 	COMPLETED 02/28/2012		
	PROVIDER OR SUPPLIER	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	Other: 9 Total: 92						
	Sample: 4						
		s reflect state findings se with 410 IAC 16.2.					
	Quality review co Cathy Emswiller						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7U2B11

Facility ID: 000069

If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2012	
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F0253 SS=E	SERVICES The facility must maintenance ser a sanitary, order! Based on observe interview, the fact shower rooms we functioning light hallways were clearly for 2 of 4 hallways Meadows and Meadows include Transition of the Vinyl tile Lane unit hallway and 128, was crascuffed. A crack concrete visible of Melody Lane unit over to the room! 2. The floor of the Room 125 on Meawith gray stains.	s, and failed to ensure ean and in good repair ys in the facility. (Faith elody Lane) The e affected 49 of 92 g in the facility. close of the facilit	F02	53	The creation and submission this Plan of Correction does no constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567L Plan Correction be considered the Letter of Credible Allegation a requests a Desk Review in lie an on-site visit on or after Mar 16, 2012. F253 Housekeeping & Maintenance Services. This facility provides housekeeping and maintenance services necessary to maintain sanitary, orderly, and comforts interior. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were ident in the alleged deficient practice. Residents who reside at facility have the potential to be affected by the alleged deficient practice. Approval has been received.	ot is t in of of of and eu of rich oce in a able in a iffied ce. t the eent	03/16/2012

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Event ID: 7U2B11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			ETED	
		155148	B. WIN			02/28/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			IRWAY DR		
NODTH I	PARK NURSING C	ENTED			VILLE, IN 47710		
	ARK NORSING C	LIVILIX		LVANO	VILLE, IN 477 10		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	ì ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					to proceed with replacement o	f	
	3. At 6:55 p.m.,	the shower room on			flooring to be completed by		
	Faith Meadows 1	Hall had a black			05-01-12. The floor of the linen closes	ood	
	substance on the	grout in both corners of			next to Room 125 has been	seu	
		er stall and the right			cleaned.		
		C			New shower room doors	for	
	corner or the sho	ower stall to the left.			all showers were ordered on		
					03/15/12.		
	4. At 7:05 p.m.,	in the shower room on			 All shower rooms have 		
	Melody Hall the overhead lights were not				been deep cleaned to include		
	functioning in the left and right shower				and switch plate on 03/08/12 b		
	stalls. During interview at this time,				Housekeeping on 03/08/12 by		
	CNA #9 indicated the switch plate next to				Supervisor/Designee. An audit was completed	of	
	the door controlled all the lights and was				the overhead lights to ensure a		
		•			lights were functioning comple		
	_ ^	plate for the lights had			on 03/08/12 by Maintenance		
	black dirt in its c	erevices.			Supervisor/Designee.		
					· The medication carts we	re	
	5. At 7:15 p.m.,	in the shower room			cleaned and placed on a routir		
	across from the l	Nurse's Station for the			cleaning schedule on 03/08/12	2 by	
	 Melody Lane_th	e overhead lights were			DNS/Designee.		
	_	n the left and right			· Chains hanging under		
	1	_			medication carts have been		
		ruring interview at this			removed by Maintenance Supervisor/Designee.		
		or of Nursing Services			Capel visoi/Designee.		
	, ,	most residents used the			How would you identify other	r	
	middle stall anyv	way. The DNS indicated			residents having the potentia		
	Maintenance wo	uld need to change the			to be affected by the same		
	lights.	_			deficient practice and what		
					corrective action will be take	n?	
	6 The doors to	the three shower rooms			 Residents who reside at 		
					facility have the potential to be		
	were observed to	be gouged and marred.			affected by the alleged deficien	nt	
					practice.		
	7. At 7:20 p.m.,	LPN #17 was observed			Approval has been recei to present with replacement of		
	passing medicati	ons on Melody Hall. A			to proceed with replacement o flooring to be completed by	'I	
	small chain was	observed hanging from			05-01-12.		
		e medication cart onto the			• The floor of the linen clos	sed	
			1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
		155148		LDING		02/28/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	L	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1			
NODTU		ENTED			IRWAY DR		
NORTH	PARK NURSING C	ENTER		EVANS	SVILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	floor, and a dust ball about three to four				next to Room 125 has been		
	inches wide was clinging to the chain and				cleaned.		
	dragging along t	he hallway. LPN #17			 All shower room doors heen ordered on 03/15/12. 	nave	
		being observed, and she			All shower rooms have		
		wipe to remove the dust			been deep cleaned to include	tile	
	ball.	, wipe to remove the dust			and switch plate on 03/08/12		
	Dall.				Housekeeping on 03/08/12 by	-	
					Supervisor/Designee.		
	During interview	v on 2/28/12 at 11:55			An audit was completed		
	a.m., the DNS pr	rovided paperwork she			the overhead lights to ensure		
	indicated was re	lated to the facility's			lights were functioning comple	eted	
	flooring. During interview at this same				on 03/08/12 by Maintenance		
	time, the Administrator indicated the				Supervisor/Designee. The medication carts we	aro	
	replacement of the cracked, crazed, and				cleaned and placed on a routi		
	•	id been approved to			cleaning schedule on 03/08/12		
		* *			DNS/Designee.	,	
	happen this year				· Chains hanging under		
		ded indicated, "Health			medication carts have been		
	•	rporation 2012 Capital			removed by Maintenance		
	Budget Request	North Park Nursing			Supervisor/Designee.		
	Center." No sign	natures on the			What measures will be put in	• • •	
	documentation in	ndicated approval or			place or what systemic	ito	
		l of the installation of			changes you will make to		
	new flooring.				ensure that the deficient		
	new mooring.				practice does not recur?		
	Duning Initial T	our or 2/26/12 at 2:20			· Housekeepers were		
	_	our on 2/26/12 at 3:30			re-educated on appropriate		
	•	nt Director of Nursing			cleaning technique of shower		
	•	f residents in the facility.			rooms, switch plates, resident	•	
	Review of the lis	st indicated 23 residents			rooms, and hall ways by the		
	lived on Melody	Lane and 26 residents			Housekeeping Supervisor on 3-8-2012.		
	lived on Faith M	leadows.			S-0-2012. Licensed nurse and aide	25	
					were re-educated on cleanline		
	This federal tag	relates to Complaint			of environment/medication ca		
	IN00103856.	Totales to Complaint			by the DNS/Nurse		
	11100103830.				Consultant/Designee on		
					3-8-2012.		
	3.1-19(f)				· Housekeeping		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155148	A. BUILDING	00 	COMPLETED 02/28/2012
	PROVIDER OR SUPPLIE	<u> </u>	B. WING STREET A 650 FA EVANS		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE ROPRIATE COMPLETION DATE
				Supervisor/Nurse manag round daily to ensure all rooms/showers are clear according to procedure.	
				How the corrective action will be monitored to ensideficient practice will not i.e., what quality assurated program will be put into an A Quality Control In the checklist will be completed compliance weekly x 4, a monthly times 3, quarter thereafter until compliance Data collected will be reverthe CQI Committee. If the foliation of 95% is not achieved, a plan will be written. What is the date by white systemic changes will be completed? March 16, 2012	sure the ot recur, nce o place? nspection ed for and y ce x2. view by ureshold an action ch the

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Facility ID: 000069

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	COMPLETED	
		155148	B. WIN			02/28/	2012	
			D. (12)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				IRWAY DR			
NORTH I	PARK NURSING C	ENTER			VILLE, IN 47710			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be pin accordance wiplan of care. Based on record facility failed to medication was aby the physician reviewed related sample of 4 (Resident D was interviewable on Assistant Director of the Initial Tout During interviewed 11:15 a.m., Resident always received and always received are desired indicated readmitted to the	QUALIFIED PERSONS/PER avided or arranged by the provided by qualified persons ith each resident's written review and interview, the ensure the resident's administered as ordered for 1 of 3 residents to physician's orders in a sident D) : identified as a list provided by the person of Nursing at the time ar on 2/26/12 at 3:30 p.m. In completed on 2/28/12 at dent D indicated he did we the suppository tance with bowel or other day. In der Resident D was 6/12 at 7:25 p.m. The the resident was a facility on 1/31/12 after ad on 1/28/12. Diagnoses	F02		F282 Services by Qualified Persons/Per Care Plan This facility provides or arranges services that are provided by qualified persons in accordance with each resident's written play of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident Directives his medication as ordered by the Physician. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take Residents who receive medication have the potential be affected by the alleged deficient practice. Licensed Nurse were re-educated on following the physician's order as written and documenting medication administration on to medication record by the DNS/designee on 3-8-2012. Audit was completed for all residents who receive suppositories to ensure no oth issues were identified. Wha measures will be put into play or what systemic changes you	ed nt n? to s he er t ce	03/16/2012	

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTR 00 A. BUILDING	(X3) DATE SURVEY COMPLETED	
	155148	B. WING		02/28/2012
	PROVIDER OR SUPPLIER PARK NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL	650 FAIRWA EVANSVILL ID	RESS, CITY, STATE, ZIP CODE /AY DR LE, IN 47710 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION
TAG	Physician's orders on the February 2012 recapitulation orders indicated an order, originally dated 2/22/10, for "Bivasc-evac 10 mg sup [suppository], insert 1 suppository rectally every other day." The Routine Medications record for February 2012 indicated the resident's medication was not administered as scheduled on 2/16/12 at 8:00 p.m The space for the nurse's initials to indicate administration was blank, and no information related to the omission was indicated. 3.1-35(g)(2)	will def rece aud rece ens diss door Number method to correct model i.e. process and the DN will Connor re-cact act write by	Il make to ensure that the efficient practice does not cur? Licensed Nurses will adit medication/treatment cords with on-coming shift to issure medications are spensed as prescribed and ocumentation is complete. Lurse Manager's will audit edication/treatment records eakly x 4 then monthly x 3 or 10% of residents to ensure impliance. How the practice action(s) will be conitored to ensure the efficient practice will not receive, what quality assurance ogram will be put into place A Medication Audit will be inducted weekly x 4 times the conthly x 3 then quarterly ereafter until compliance x2 NS/Designee. Data collect ill reviewed by the CQI ommittee. Those found to be on-compliant will receive education up to disciplinary tion. If threshold of 95% is not the completed? March 16, which the systemic chang II be completed? March 16,	ur, e? en by ed c ot

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 02/28/2012	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	WELL BEING Each resident m must provide the services to attai practicable phys psychosocial we the comprehens care. Based on record facility failed to resident's bowel including admin suppository, as for 1 of 1 reside bowel managem (Resident D) Findings include Resident D was interviewable on Assistant Direct Tour on 2/26/12 During interviev 11:15 a.m., Resi problem with ca related to his bo indicated he was suppository to a movements even Wednesday, Frie Tuesday, Thurse	identified as a a list provided by the or of Nursing on Initial at 3:30 p.m. v completed on 2/28/12 at ident D indicated a are he encountered was wel regimen. Resident D as supposed to receive a	F0309	F309Services by Qualified Persons/Per Care Plan This facility provides or arranges services that are provided by qualified persons in accordance with each resident's written plat of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Reside Directives his medication a ordered by the Physician. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taked. Residents who receive medication have the potential be affected by the alleged deficient practice. Licensed Nurse were re-educated on following the physician's order as written and documenting medication administration on the medication record by the DNS/designee on 3-8-2012. Audit was completed for all residents who receive suppositories to ensure no other controls.	ed nt as al n? to

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	AND PLAN	OF CORRECTION IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING	00	COMPLETEI 02/28/201	D
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH DEFICIENCE) ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETICE	NORTH (X4) ID	PARK NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES	STREET ADDR 650 FAIRW EVANSVIL	VAY DR LE, IN 47710 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	E CO	
suppository correctly, and others didn't. Resident D indicated the record always showed the nurses gave the suppository, even when he knew they did not do so. Resident D indicated he requests the suppository at 9:00 p.m., but sometimes the nurse gives it at 10:30 p.m., and then he falls asleep before it is effective. Resident D indicated the suppository usually worked within about 15 minutes. Resident D indicated the had been in the hospital in the past for problems with his bowel, because he was constipated. In a subsequent interview on 2/28/12 at 5:20 p.m., the resident indicated he was sure he would receive the suppository today, because the nurse who was working gives the medication. He indicated the doctor in the past had told him he could die if his bowels did not move regularly. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia. Physician's orders on the February 2012 recapitulation orders indicated orders including, but not limited to, quadriplegia. Source dentified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice will audit medication/treatment records with on-coming shift to ensure medications are dispensed as prescribed and documentation is complete. Nurse Manager's will audit 100% of medication/treatment records monthly x3 then quarterly x2 until 95% compliance is achieved. Data collected will reviewed by the CQI Committee. Those found to be non-compliant will receive re-education up to disciplinary action. If threshold of 95% is not achieved an action plan will be written. What is the date by which the systemic changes will be completed? March 16, 2012	TAG	suppository correctly, and others didn't. Resident D indicated the record always showed the nurses gave the suppository, even when he knew they did not do so. Resident D indicated he requests the suppository at 9:00 p.m., but sometimes the nurse gives it at 10:30 p.m., and then he falls asleep before it is effective. Resident D indicated the suppository usually worked within about 15 minutes. Resident D indicated he had been in the hospital in the past for problems with his bowel, because he was constipated. In a subsequent interview on 2/28/12 at 5:20 p.m., the resident indicated he was sure he would receive the suppository today, because the nurse who was working gives the medication. He indicated the doctor in the past had told him he could die if his bowels did not move regularly. The clinical record for Resident D was reviewed on 2/26/12 at 7:25 p.m. The record indicated the resident was readmitted to the facility on 1/31/12 after being hospitalized on 1/28/12. Diagnoses included, but were not limited to, quadriplegia. Physician's orders on the February 2012 recapitulation orders indicated orders including, but not limited to, Miralax (stool softener/laxative) daily (originally	iss m or wi de re au re er dii do Ni of m 95 Hi wi de i.e pr	sues were identified. Wheasures will be put into play in what systemic changes you ill make to ensure that the eficient practice does not exur? Licensed Nurses was undit medication/treatment ecords with on-coming shift insure medications are spensed as prescribed and ocumentation is complete. The words with a systemic spensed as prescribed and ocumentation is complete. The words will audit 10 for medication/treatment reconsonthly x3 then quarterly x2 for compliance is achieved ow the corrective action(sill be monitored to ensure eficient practice will not reconstruct the systemic changes will audit 20% of medication/treatment ecords monthly x3 then quarterly x3 then quarterly x3 then quarterly x4 the cords monthly x3 then quarterly x5 what quality assurance ecords monthly x3 then quarterly x6 monthly x3 then quarterly x6 monthly x3 then quarterly x6 monthly x3 then quarterly seconds to be non-compliantly action. If thresholds is not achieved an action an will be written.	nat lace you vill to 00% ords until s) e the ecur, it nt rterly e is vill ttee. bliant to on //hat	DATE

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Event ID: 7U2B11

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		A. BUILDING B. WING	00	COMP	LETED 3/2012	
	PROVIDER OR SUPPLIER		650 FA	ADDRESS, CITY, STATE, ZIP C IRWAY DR VILLE, IN 47710	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	every other day [2/22/10]," and Cdaily (originally resident also had Magnesia (laxaticonstipation (originally dated). The Care Plan Uindicated a probligoal of "[symbolinterventions of lab as ordered." The Routine Med February 2012 in medication was a scheduled on 2/1 space for the nuradministration w	Colace (stool softener) dated 12/13/11). The corders for Milk of ve) as needed for ginally dated 12/31/07), a once daily as needed 12/2/11). pdate, dated 12/13/11, em of constipation, with for no] constipation, and "Meds [medications] and dications record for ndicated the resident's not administered as 6/12 at 8:00 p.m The se's initials to indicate				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		155148				02/28/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NODTU		NITED			IRWAY DR		
NORTH	PARK NURSING CE	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(EACH CORRECTIVE ACTION SHOULD BE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			-	DATE	
F0312 SS=D	483.25(a)(3) ADL CARE PRO RESIDENTS A resident who is of daily living rec to maintain good personal and ora Based on observa record review, th residents receive personal hygiene reviewed related in a sample of 4. Findings include 1. On 2/27/12 a was observed du by CNAs #16 an resident's feet we	VIDED FOR DEPENDENT s unable to carry out activities eives the necessary services nutrition, grooming, and all hygiene. ation, interview, and e facility failed to ensure d assistance to maintain for 2 of 3 residents to showers and bathing (Residents B and D) t 9:35 a.m., Resident B ring a bed bath provided d #22. The bottom of the are observed to have	F03		F312 ADL Care Provide For Dependent Residents. To facility provides to residents where are unable to carry out activities of daily living the necessary services to maintain good nutrition, grooming, and personand oral hygiene. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident B is provided bed bath in accordant with the standard of practice. Resident D receives his shower.	d his ho es nal	DATE 03/16/2012
	resident's lower l washed, and the	inging to them. The egs and feet were not resident's feet were lint on the bottom when			in the evenings per his reques Resident is offered a bed bath when he refuses a shower. How will you identify other		
		pleted and the resident			residents having the potentia to be affected by the same deficient practice and what corrective action will be take	n?	
	list of interviewa Assistant Directo Initial Tour on 2/ During interview at 11:15 a.m., Re	ame was included on a ble residents provided by or of Nursing during 26/12 at 3:30 p.m. completed on 2/28/12 esident D indicated he or showers on Monday,			· Residents who are depende on staff for ADL care has the potential to be affected by the alleged deficient practice. · A residents are offered showers resident's choice of time. Tho who refuse showers are offere bed baths. · Licensed Nurse Certified Nursing Assistants we re-educated related to offering	II per se d and ere	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		a. Building 00			COMPLETED	
		155148				02/28/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	ER						
NODTU		SENTED			IRWAY DR			
NORTH	PARK NURSING (JENTER		EVANS	SVILLE, IN 47710			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Wednesday, and	d Friday. The resident			bed bath when a resident refu	ses		
	indicated he pre	eferred his showers in the			shower by the DNS/Nurse			
	_	did not happen the week			Consultant on 03-08-12 Post t	est		
	_	e indicated he did not			was completed. · Certified Nursing Assistants and Licens	hod		
		ath as a substitute for the			Nurses were re-educated on the			
		atil as a substitute for the			proper documentation for care			
	shower.				3-8-2012. Certified Nurses			
					Aides were re educated on pro	oper		
	The clinical rec	ord for Resident D was			technique of Bed bath comple	ted		
	reviewed on 2/2	26/12 at 7:25 p.m.			on 03-15-12 by			
					DNS/SDC/Designee. Certifi			
	The resident's care plan, with Problem				Nurses Aides who performed	the		
		2/2/11, indicated the			bath were one on one re	on		
		elf-care deficit with			educated with DNS/Designee 03/15/12. What measures			
					will be put into place or what			
		ly living (ADL) related to			systemic changes you will	,		
	quadriplegia.				make to ensure that the			
					deficient practice does not			
	CNA Assignme	ent Sheet for Resident D			recur? · The ADL grids are			
	was provided d	uring the Initial Tour on			reviewed daily in the morning			
	2/26/12 at 3:30	p.m. The assignment			clinical meeting for identified			
		sident was scheduled for			issues. Executive			
		nday, Wednesday, and			Director/designee will attend the	ne		
	Friday on the ev				Resident Counsel Meeting monthly times three to identify			
	Filday on the ev	vening sinit.			care issues. • Process was p			
					into place if resident refuses	ut		
		ADL Records for January			shower/ Supervisor is informed	d of		
	2012 indicated	the following:			refusal and is re approached b	у		
					supervisor/and bed bath is			
	Week of Januar	ry 1: 1 shower, 1 bed bath;			offered. If resident refuses			
	no refusals				resident is asked to sign refus	al		
	Week of January 8: no shower, 1 bed				on shower sheet. How the			
					corrective action(s) will be			
bath; no refusals				monitored to ensure the deficient practice will not rec				
Week of January 15: 1 shower, no bed bath; no refusals				i.e., what quality assurance	ui,			
				program will be put into plac	۵2 ا			
		y 22: 2 bed baths, 1			Social Services will condu-			
shower; no refusals				Coolai Coi vices wiii coi idu	~`			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			RVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLET	ΈD
		155148	B. WIN			02/28/20	012
NAME OF B	AN OLUMBER OR GUIDRU IEI				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	ę.		650 FAI	RWAY DR		
	PARK NURSING C	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	+	DATE
	· ·	as hospitalized 1/28/12		interviews with 100% of the residents regarding compliance		_	
	through 1/31/12.) The resident's ADL Records for February				with showers monthly x3 then		
					quarterly x2 until threshold of 95% is achieved. Data gathered		
						ered	
	2012 indicated the	he following:			will be reviewed by the CQI		
	Week of February 1: 2 showers; (One refusal on the same day/shift the shower was documented as given) Week of February 8: 1 bed bath; no refusals				committee. If threshold of 95%		
					not achieved, an action may b developed. What is the date		
					by which the systemic chang		
					will be completed? March 16,		
					2012		
	Week of Februar	ry 15: no showers, 2 bed					
	baths; 1 refusal	.,,					
	· ·	ry 22 (through 2/28/12					
		ower, 2 bed baths; no					
	refusals.	lower, 2 dea dams, no					
	Tetusais.						
	This follows to a	malatas ta Camanlaint					
	_	relates to Complaint					
	IN00103856.						
	3.1-38(a)(3)(A)						

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETE				
		155148	B. WIN	G		02/28/	2012
NORTH F	PROVIDER OR SUPPLIER	ENTER		650 FAI EVANS	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
F0314 SS=D	483.25(c) TREATMENT/SY PRESSURE SO Based on the co a resident, the faresident who ent pressure sores of sores unless the demonstrates the and a resident hareceives necessare promote healing prevent new sore Based on observent interview, the fact residents with praccurately assess notified, and treat prevent new and for 2 of 3 resident wounds in a same and D) Findings included 1. The clinical reviewed on 2/20 record indicated readmitted to the being hospitalized included, but we quadriplegia. The resident's care	mprehensive assessment of acility must ensure that a ers the facility without loes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing. ation, record review, and cility failed to ensure essure ulcers were sed, the physician was atments were provided to recurring pressure ulcers ats reviewed related to ple of 4. (Residents B	F03	14	F314 Treatment/SVCS to Prevent/Heal Pressure Sores This facility based on the comprehensive assessment or resident ensures that a resident who enters the facility without pressure sores does not devel pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receive necessary treatment and servi to promote healing, prevent infection and prevent new sore from developing. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident D is receiving of and services per physician or to promote wound healing. The wound is decreasing in size.	f a nt op s ces	DATE 03/16/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	ETED
		155148	B. WIN			02/28/2	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IRWAY DR		
NORTH	PARK NURSING C	FNTFR			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG	†	LISC IDENTIFYING INFORMATION)		TAG			DATE
) [history of] pressure			Resident's care is updated to reflect resident's non-compliar		
		ent pressure ulcer			with care and treatment and		
	RESIDENT IS N	NONCOMPLIANT			impaired skin integrity.		
	WITH LYING I	OOWN." The goal, with			· Resident B is provided c	are	
	target date of 3/2	2/12, indicated the			and services to promote woun	d	
	_	ave healing of the current			healing.		
	ulcer and remain free of further skin						
	breakdown. Approaches included, but were not limited to, encouraging the				How will you identify other		
					residents having the potentia	11	
					to be affected by the same deficient practice and what		
	resident to adhere to the scheduled time up and change positions frequently in the wheel chair, with intervention start date of				corrective action will be take	n2	
					Residents who are at ris		
					have pressure ulcers have the		
	12/2/11. Other i	nterventions in place			potential to be affected by the		
	since 1/6/11 incl	uded, but were not			alleged deficient practice.		
	limited to, "Trea	tment of pressure ulcer			· Licensed Nurses were		
	· ·	as ordered - observe for			re-educated by the DNS/desig		
	, •	mptoms] of increasing			on the wound program includir documentation on 3-8-2012.	ng	
		nges with s/s infection -			· The Certified Nursing		
	· ·				Assistants were re-educated o	n l	
	notify physician.	-			wound prevention and		
		d been added since			intervention i.e. pillows betwee	n	
	12/2/11.				knees, turning and repositionir	ng,	
					peri-care by DNS/Designee.		
	The resident's ca	re plan also included, but			NAME - 4	4 -	
	was not limited t	to, "Problem start date:			What measures will be put in	το	
	10/31/11 Reside:	nt is resistive to care as			place or what systemic changes you will make to		
	evidenced by: R	Resident is non-compliant			ensure that the deficient		
	1	e, he refuses to lay of his			practice does not recur?		
		•			Residents are assessed	for	
	bottom [sic], he refuses to let the nures [sic] apply treatment. Interventions had				pressure risk upon admission,		
	not been revised				quarterly, and with significant		
	not been revised	Since 10/31/11.			change.		
					Preventative measures a		
		re plan also included, but			put into place upon identification of a resident at risk.	ווע	
	was not limited t	to, "Problem start date:			The Interdisciplinary wou	_{ınd}	
	2/27/12 Residen	t has impaired skin			team rounds weekly to review		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155148	B. WIN			02/28/2012
NAME OF B			_		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF			650 FA	IRWAY DR	
	PARK NURSING C	ENTER			VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	· ·	DATE
		ht] upper inner thigh."			those residents with wounds a those at risk to ensure	na
	1	ntion included in the			appropriate treatments and	
	l * '	not also included in the			interventions are in place.	
	plan dated 1/6/1	1, was "Labs as ordered."			Licensed Nurses assess	
	A Nurse's Note, dated 1/25/12 at 7:00 a.m., indicated, "IDT [interdisciplinary				resident's weekly head-to-toe	
					identify any skin integrity issue	
					 Licensed Nurses will rou per shift 7 days weekly to ensu 	
	team] wound rou	ands this AM [morning]			compliance with resident plan	
	appears as excoriation with two small open areas. Team recommends EPC [Extra Protective Cream] q [every] shift and prn [as needed]. Call to [name of				care.	
					How the corrective action(s)	
					will be monitored to ensure t	
		ian] for orders. Triage.			deficient practice will not rec	ur,
					i.e., what quality assurance	•2
	D/C [discontinue	e] previous orders."			program will be put into plac A Wound CQI tool will be	
	l				utilized weekly times four and	´
		in the record failed to			monthly 3 then quarterly	
		ements of the excoriated			thereafter until compliance x2	
	area or "two sma	all open areas."			DNS/Designee. Data gathere	:d
					will be reviewed by the CQI committee. If threshold of 95%	/ ia
	During interview	v on 2/28/12 at 11:55 a.m.			not achieved, an action may b	
	in regard to the r	neasurements of the open			developed.	
	areas, the Direct	or of Nursing Services			'	
	i i	the facility would not			What is the date by which the)
		et" related to the wound,			systemic changes will be	
		coriation," but she			completed?	
	indicated she wo	· · · · · · · · · · · · · · · · · · ·			March 16, 2012	
		n a thinned record.				
		a a aminiou roomu.				
	During interview	y on 2/28/12 at 12:45				
	_	rovided a "Wound Skin				
	1 * .					
	Evaluation Report" indicating "Date					
		ed" was 12/6/11 on "R				
		h [arrow pointing up -				
	upper]." The do	cumentation indicated the				

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	OF CORRECTION OF CORRECTION 155148	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/28/2012			
	PROVIDER OR SUPPLIER PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION			
	wound was excoriation of 0.5 by 0.5 cm length by width with no depth, no tunneling, red color, scant drainage, and no odor on 12/6/12. The documentation indicated the measurements decreased in size with no open areas until 1/18/12, when the size was 0.3 by 0.2 cm. The documentation for 1/25/12 indicated the wound was 0.1 by 0.1 cm with no depth, no tunneling, red color, no drainage. In the area for "Comments" was "Slightly open." No measurements of the two open areas mentioned in the Nurse's Notes were indicated. The Treatment Orders record for January 2012 included, but was not limited to, the following: An order for "EPC Cream to buttocks/perineum twice daily and as needed" had an original order date of 9/28/11. The entry indicated with a nurse's initials that the treatment was administered as follows: twice daily from January 1 through January 16, 2012; once daily from January 17 through January 27, 2012; not administered 1/28/12; and administered once daily on 1/29/12. (The resident was hospitalized on 1/29/12.) A circle was drawn around the dates of 1/30 and 1/31/12.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/28/2012	
	PROVIDER OR SUPPLIED		650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR VILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	An order for "See (EPC) Apply to information]" w 12/8/11. No nur the entry. An order for "See (EPC) Apply cree twice daily and a had an original of nurse's initials in the treatment was daily from Januar and not administrated to ischial Rt [rig [as needed] soila until resolves." entry indicated the administered that through 26, 2012 January 27, 2012. Nurse's notes indischarged to the returned on 1/31. The American See Nursing Admission.	right thigh - [no further ith original order date of rse's initials were next to recura Protective Cream eam to buttock/peri area as needed for soilage," order date of 8/19/11. A ext to the entry indicated as administered twice ary 1 through January 26, tered on 1/27/12. 1/25/12 for "EPC Cream ht] q [every] shift & prn age to excoriated area Nurse's initials next to the he treatment was ree times daily January 25 2, and two times on 2. dicated the resident was re hospital on 1/28/12 and	TAG	DEFICIENCY)	DATE
	· ·	[right] ischial" with			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	COM	te survey ipleted 28/2012	
	PROVIDER OR SUPPLIER		STREET 650 F.	T ADDRESS, CITY, STATE, ZIP (AIRWAY DR ISVILLE, IN 47710	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	in regard to furth wound, the DNS	on 2/28/12 at 2:15 p.m. her description of this indicated she would v" records to see what				
	located and provindicated, "Date Admit." This do describing the wand one on 2/8/1 information entry indicated the working the	und was a Stage 2, 4.2 th no depth, no tunneling, unulating, "rubra"				
	2/2/12 indicated, a.m. [morning] v et [and] observed	Progress Notes for "IDT wound rounds this isualized R [right] ischial d excoriation" The cate a plan related to the				
	indicated, "Secur (EPC), apply to e ischial every shift soilage until reso order date of 1/2 next to the entry was administered	orders for February 2012 ra Protective Cream excoriated area of right ft and as needed for olved," with an original 5/12. Nurse's initials indicated the treatment d three times per day as for the following dates				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/28/2012	
	PROVIDER OR SUPPLIE PARK NURSING C		650 FA	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR VILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	twice: 2/5, 2/6, 2/19, 2/21, and 2 the treatment wa on 2/22/12, and Nurse's notes for indicated, "Als [treatment] to ar [symbol for with increased] redner Physician Telep 2/3/12, included "Neosporin BID then call [symbol for with increased] redner Physician Telep 2/3/12, included "Neosporin BID then call [symbol for with increased] redner Physician Telep 2/3/12, when it was administere 2/8/12, when it was administered 2/8/12, when it was administer	hone Orders, dated , but were not limited to, [twice daily] X 10 days of for with] update." It is record for February he Neosporin treatment d twice daily except was administered only one ound Skin Evaluation (12, indicated the right has a Stage 2, 4 cm by 2 h and no tunneling. tted to tissue type,			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	
		155148	B. WING			02/28/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH F	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated, "Resident up in W/C [wheel						
		refused to lie down in					
	·	essure to buttocks, back					
	to bed at 21:30 [
		oleted, noted change to R					
		ments taken, placed on					
	pressure area ass	essment skin sheet, noted					
	moderate amoun	t bloody drainage, no					
	odor, refused to	lie on left side [symbol					
	for after] being p	placed in bed, [illegible					
	word] non-comp	liant [symbol for with]					
	repositioning, un	iderstands effects."					
	Documentation f	failed to indicate the					
	change in the wo	ound was reported to the					
	physician.	•					
	The Pressure Wo	ound Skin Evaluation,					
	mentioned in the	Nurse's Notes as started					
	on 2/13/12, indic	cated the wound was					
	· ·	ssion, with "Date Wound					
	Developed: Adr						
		t to this was: "Area was					
		ious hospital." The first					
	· •	on entry, dated 2/13/12,					
		und was Stage 2, 3.9 cm					
		s than 0.1 cm depth, no					
		lating tissue, moderate					
	bloody drainage.						
	, ,	icated, "Area [symbol for					
		2 3					
		areas now one area, Tx					
	[treatment] giver	i as ordered.					
	A Nurse's Note.	dated 2/17/12 at 10:00					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155148	B. WING		02/28/2012
NAME OF F	PROVIDER OR SUPPLIE	B	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
				IRWAY DR	
NORTH I	PARK NURSING C	ENTER	EVANS	VILLE, IN 47710	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTRIBUTION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCI)	DATE
	_	"existing wound on			
		as noted to be oozing			
		one nurse for [name of			
		eian] reinstated the old			
	<u>-</u>	n gentle 4 X 4 apply to			
		cleaning with normal			
	_	every 3 days or prn for			
	dislodgement. V	Will continue to monitor."			
	Treatment Orders record for February				
	2012 indicated the order was transcribed				
	onto the record. No entries indicated				
	dates the treatme	ent was planned to be			
	administered. N	To entries indicated the			
	treatment was ac	dministered.			
	The Pressure W	ound Skin Evaluation			
	entry for 2/20/12	2 indicated the wound was			
	a Stage 2, 3.5 cm	n X 2.8 cm X less than			
	0.2 cm with no t	unneling, and granulation			
	tissue. The colu	mn for documenting			
	drainage was bla	ank. "Comments"			
	indicated, "Impr	oving." An entry for			
	_	d the wound was Stage 2,			
		than 0.2, no tunneling,			
		ie, no drainage, and no			
	_	nts" indicated, "Therapy			
		es for 2/20 and 2/24/12			
	were signed by i				
	On 2/27/12 at 8:	35 a.m., the DNS was			
	observed at the i	nurse's station on Resident			
	D's hall. During	g interview at this time,			
	the DNS indicat	ed the resident would be			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/28/2012		
	PROVIDER OR SUPPLIER			650 FAI	ADDRESS, CITY, STATE, ZIP CODE RWAY DR VILLE, IN 47710	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	receiving mist the morning. She in having good such she indicated the non-compliant were lief to the area which had healed numerous times. The resident went to the wound was just the hospitalization ulcer. On 2/27/12 at 9:0 indicated the resimist therapy to hentrance to the resimist therapy to hentrance to the resident was in was observed to beefy red wound PTA [Physical Twas at the bedsic treatment as ultrated a mist of normal ultrasound more wound bed and remoisture. The Dand asked PTA indicated she did had discarded the statement of the resident properties of the properties of	erapy to his wound this dicated the facility was bees with the treatment. The resident was ith care and pressure on the right ischial, and re-opened. She indicated when the the hospital on 1/28/12, ast excoriation but after on was a Stage 2 pressure. The resident was ready for the is wound. Upon esident's room, the process. The resident have an open, moist, to the right ischial area. The herapist Assistant] #3 the providing the was a wound using saline, which made the effective in reaching the maintaining wound NS was at the bedside was a wound to a wound had removed. PTA #3 not notice the date and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING	COMPLETED 02/28/2012
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710	3
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
indicated, "Pt [patient] to recv [receive] PT [physical therapy] 3/wk [three times a week] for wound care inclusive of mist therapy to R LE [lower extremity] [sic] to promote healing" Nurse's notes for 2/27/12 at 3:10 p.m., indicated," Call triage for tx. [treatment]. Tx denied at this time. Wants recommendation from wound team. ADON [Assistant Director of Nursing] notified. Therapy Observation Reports for assessment of the resident's wound indicated the following: Two Therapy Assessment reports with "Observation Date: 2/24/12" and "Date Recorded: 2/28/12" indicated "Reason for referral: resident presents with 2 wounds at posterior thigh/buttocks with narrow separation." The first report indicated the first wound was "right posterior thigh/buttocks - upper and lateral region." The wound was Stage 2 with suspected origin of pressure and shearing. The length, by width, by depth, using a clock method		
was 3.3 cm X 2.7 cm X 0.2 cm with scant exudate and no odor. The second report indicated the second		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	155148		LDING	00	COMPLETED 02/28/2012	
		100140	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/20/2012	
NAME OF F	PROVIDER OR SUPPLIER	t .			RWAY DR		
	PARK NURSING CI	ENTER			VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	E COMPLETIO DATE	N
1710	wound was a right	<u> </u>	+	1110		BATE	-
	_	ound at lower medial					
	"	nd was Stage 2 with					
	~	of pressure and shearing.					
		ridth, by depth, using a					
		as 5.2 cm X 3.1 cm X 0.2					
		audate and no odor.					
	During interview	on 2/28/12 at 2:05 p.m.,					
	the Director of Rehab Services indicated						
	Resident D started the mist therapy to his						
	wound on 2/27/1	2.					
	Danidant Dania	lists 1 intomicroslate					
		listed as interviewable on					
	_	by the Assistant Director					
	at 3:30 p.m.	e Initial Tour on 2/26/12					
	at 3.30 p.m.						
	During interview	completed on 2/28/12 at					
	11:15 a.m., Resi	dent D indicated staff					
	does not assist hi	im routinely to reposition					
	in bed. He indic	ated staff sometimes is					
	not careful when	assisting him to don					
	1 ^	he pants are not scraped					
		d to his buttocks. The					
		icated the straps to the					
	_	imes scrape across the					
	buttock wound.						
	On 2/28/12 at 11	:45 a.m., the DNS					
	provided a second copy of Resident D's Treatment Orders record for February						
		f the documentation					
		lowing next to the entry					
	I	-	- 1				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
11112 12111	or confidence.	155148		LDING		02/28/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				RWAY DR		
NORTH I	PARK NURSING C	ENTER		EVANS	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		tle 4 X 4 apply to open		TAG	DLI ICIENCI)		DATE
		ng with normal saline.					
	Change every 3						
		A box was now drawn					
	_	ving dates: 2/17, 2/20,					
		2. A nurse's initial was					
		each of the boxes.					
	At this time the I	ONS also provided copy					
	of a Pressure Wound Skin Evaluation						
	Report and indicated it showed						
	documentation of a second wound to the						
	resident's right ischial area. She indicated						
	•	e two wounds had					
	-	wound. The Report					
		und was not present on					
		eveloped on 2/24/12.					
		he wound indicated, row pointing down]."					
		/24/12, indicated the					
	_	ge 2, with length of 5.2					
		cm, and depth of 0.2 cm.					
	The documentati	_					
		type "red," slight					
	drainage, and no						
	-	tion was "PT [Physical					
	Therapy]/Nursin	g." The documentation					
	was signed with	the initials of the					
	Physical Therapi	st who completed the					
	Therapy Observa	ntion Reports, dated					
		to the resident's two					
	wounds to the rig	ght ischium.					
	During interview	on 2/28/12 at 2:15 p.m.					
							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE : COMPL		
		155148		LDING		02/28/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER				RWAY DR		
NORTH I	PARK NURSING C	ENTER		EVANS'	VILLE, IN 47710		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	evised Treatment Order indicated she had drawn					
	boxes around the						
		be been administered.					
		nile she and the Corporate					
		t were talking to the					
		e for the dressing changes					
	_	documentation, the					
	nurse filled in he	•					
	During interview	on 2/28/12 at 2:45 p.m.,					
LPN #4 indicated she was sure she had							
	done the dressing changes for Resident D,						
	so she filled in h	er initials During					
	interview at this	same time, the DNS					
		se "thought it was what I					
		, since I had drawn the					
		e appropriate dates on					
	the Treatment Or	rders form.					
	During interview	on 2/28/12 at 3:05 p.m.,					
	_	porate Nurse Consultant					
		d recently inserviced the					
		Team and nursing staff					
		The Consultant provided					
		ce records. Review of					
	-	on at this time indicated					
	an outline for "Ic	lentification and					
	Prevention of W	ounds OutlineWhat					
	does the nurse do	when we have a skin					
	issue: 1. Assessi	ment!!!!! 2. Notify					
	physician and far	mily 3. Appropriate					
	treatment 4. Rec	luce pressure. What does					
	the nurse do to p	romote wound healing?					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155148	B. WIN	G		02/28/2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
NODTIL					RWAY DR	
NORTH	PARK NURSING CI	ENTER		EVANS	VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
	1. Do the treatment!!!! and Degument!!!! 2. Monitor the greate					
	Document!!!!! 2. Monitor the area to					
		using bolsters, pillows,				
	_	oning" The Consultant				
	indicated LPN #4 attended the inservice.					
	2 774 . 11 . 1					
	2. The clinical record for Resident B was					
	reviewed on 2/26					
		ded, but were not limited				
	to, paraplegia and brain injury.					
	Decree of West of Clin Foot of the Decree					
	Pressure Wound Skin Evaluation Report,					
		ted 2/24/12, indicated				
		a Stage 3 pressure ulcer				
	to the coccyx.					
	The come when you	ith "Duahlam Start Data"				
		ith "Problem Start Date"				
	·	ated, "Resident is at risk				
		wn r/t [related to]				
		e goal, with Goal Target				
		ndicated, "Resident will				
		her skin breakdown."				
		st recently dated 3/30/1,				
	included, but we	·				
	rieventative tre	eatment as needed."				
	The CNA Assist	nment Sheet for Resident				
		during the Initial Tour on				
		•				
	2/26/12 at 3:30 p.m. The "Special Needs" section for Resident B included, but was					
		Dress in long pants at				
		ce pillow between legs in				
	bed"	ce pinow octween legs in				
	DEU					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155148	A. BUILDING 00		00	COMPLETED 02/28/2012	
		100110	B. WIN		DDDECC CITY CTATE ZID CODE	02/20/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE RWAY DR		
NORTH I	PARK NURSING CE	ENTER			VILLE, IN 47710		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		ted 12/20/11 at 10:30		TAG	Birteliatery		DATE
	· · · · · · · · · · · · · · · · · · ·						
		1 at 9:00 p.m., indicated					
		non-compliant with					
	keeping a pillow	between his legs.					
	Physician's rewri	te orders for February					
	•	ut were not limited to,					
	· ·	ents to the Stage 3					
		nd skin prep to wounds to					
	1	shin, right knee, and left					
	heel. The wound						
	extremities were						
	non-pressure wou						
	non probbate wee						
	On 2/27/12 at 9:3	35 a.m., Resident B was					
		a bed bath provided by					
	_	22. The resident was in					
		ly to the right. When the					
	_	removed from Resident					
	B's legs, the legs	were positioned to the					
		of the other. The legs					
	-	nd had no padding					
		sing was observed to the					
		o red marks were					
	_	eft shin. On the right					
		l indented scar which					
		nter. When the bed bath					
		e resident was dressed in					
	_	own and no pants were					
		low or padding was					
	_	he resident's legs.					
	pacea servicin ti	1001401110 1050.					
	During interview	when the CNAs left the					
	_	ed bath, Resident B					
			<u> </u>				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED 02/28/2012		
		155148	B. WIN	G		02/28/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NORTH F	PARK NURSING CE	ENTER			RWAY DR VILLE, IN 47710		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		ld be willing to try a					
	•	is legs to prevent					
	pressure.						
	During interview	on 2/28/12 at 3:20 p.m.,					
	_	ed she was not Resident					
	B's nurse but cou						
	information abou						
		arn if the resident had a					
		is legs, she indicated she					
	•	she thought he probably					
		a pillow between his					
	legs. CNA #24 a						
	observation of Re	esident B in bed at this					
	time. The residen	nt's lower legs were bare					
	and lying one on	top of the other, and no					
	pillow or padding	g was between the legs.					
	When asked, the	resident indicated he was					
	willing for a pillo	ow to be placed between					
	the legs. CNA #2	24 indicated no spare					
	pillow was in the	room, and she went to					
	the linen closet.	She indicated no pillow					
	was in the closet.	Laundry/housekeeper					
		by and indicated he					
	•	illow from laundry, and					
	•	provided. CNA #24					
		between the resident's					
	-	d the resident's bed					
	covers.						
		1					
	_	relates to Complaint					
	1N00103856 and	Complaint IN00104314.					
	3.1-40(a)(1)						

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	OF CORRECTION	IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING	00		LETED B/2012			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
PREFIX				(EACH CORRECTIVE ACTION S	SHOULD BE	COMPLETION			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155148	B. WIN			02/28/	2012
NORTH F	PROVIDER OR SUPPLIER	ENTER		650 FAI EVANS	ADDRESS, CITY, STATE, ZIP CODE IRWAY DR VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	BLADDER Based on the resident who entindwelling cathet the resident's clin that catheterizatire sident who is in receives approprion prevent urinar restore as much possible. Based on observative record review, the staff handled the with practices to infections. (Residented to a uroloon The deficient praresidents reviewed urinary catheters (Residents C and Findings include 1. On 2/26/12 at wound dressing with the dining room the defining room the defining room of the resident control	: 4:10 p.m., Resident C's was observed with LPN as at the bedside with eel chair, and during time, CNA #7 indicated g to assist the resident to	F03	15	F315 No Catheter, Prevent UT Restore Bladder This facility based on the resident's comprehensive assessment ensures that a resident who enters the facility without an indwelling catheter not catheterized unless the resident's clinical condition demonstrates that catheterizat was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore a much normal bladder function possible. What corrective action(s) will be? accomplished for those residents found to have been affected by the deficient practice? Resident C catheter is maintained using infection control.	is tion t t y as as	03/16/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DDIG	00	COMPLETED
		155148	A. BUILDING B. WING		02/28/2012
		L		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		AIRWAY DR	
NORTH	PARK NURSING C	ENTER		SVILLE, IN 47710	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	yellow urine was observed lying folded			 Resident D saw the Urologist 	
	over on the floor. LPN #17 did not			On 03-09-12 with no new order	ere
	remove the bag	from the floor, and she		received.	
	did not instruct	CNA #7 to remove the			
	bag from the flo	or.		How will you identify other	
				residents having the potenti	al
	On 2/26/12 at 4:20 p.m., Resident C was			to be affected by the same	
		•		deficient practice and what	
	observed in his wheel chair using his feet			corrective action will be take	en?
	to propel himself toward the dining			 Residents with urinary catheters have the potential to 	a ha
	room. The resident's catheter bag was in			affected by the alleged deficie	I
	a dignity bag under the wheel chair, and			practice.	3110
	the bag dragged along the floor. The			· Audit was completed of	all
	catheter tubing was observed to drag			urinary catheters on 03-08-12	
	along the floor,	and the resident was		with no other issues found.	
	observed to step	on the tubing with his		Licensed Nurses and	
	shoe as he prope	elled himself along.		Certified Nursing Assistants h	I
		2		been re-educated on catheter care as to maintain infection	
	On 2/27/12 at 1	1:30 a.m., Resident C was		control by the DNS/Nurse	
		at a table in the dining		Consultant on 3-8-2012.	
				· Licensed Nurses were	
		lent's catheter tubing was		re-educated on proper follow	up
		floor under the wheel		on physician orders by	
	chair.			DNS/designee on 3-8-2012.	
				What measures will be put in	nto
	The clinical reco	ord for Resident C was		place or what systemic	
	reviewed on 2/2	6/12 at 4:35 p.m. The		changes you will make to	
	record indicated	the resident had a supra		ensure that the deficient	
	pubic catheter.			practice does not recur?	
	_			Licensed Nurses will rou	I
	The resident's co	are plan, with "Problem		every shift to ensure compliar	nce
		-		with infection control.	
	Start Date: 4/8/11" indicated, "Problem:			Nurse Managers will rou deily shift to appure Falou	und
	Resident has chronic urinary tract			daily shift to ensure Foley catheters are being maintaine	. _d
	infections." The goal, with Goal Target			appropriately.	·u
		indicated, "Resident will		Nurse Managers will pla	nce
	be free of signs/	symptoms of urinary tract		needed follow up on the	

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155148	B. WIN	NG		02/28/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					RWAY DR		
NORTH I	PARK NURSING CE	=NTER		EVANS	VILLE, IN 47710		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	infections (UTI).	"			Continuous Quality Improvement		
					minutes to ensure appropriate follow up has been completed		
	A physician's order, dated 2/20/12,				lonow up has been completed	•	
	indicated urinaly	sis with culture and			How the corrective action(s)		
	sensitivity.				will be monitored to ensure t	he	
					deficient practice will not rec	eur,	
	Nurse's notes, da	ted 2/25/12 at 4:00 p.m.,			i.e., what quality assurance		
	· ·	ived N/Os [new orders]			program will be put into plac ·Check list Nurse rounds is	e	
	D/T [due to] lab				being completed every shift to		
	[10]10	. ,			ensure catheter compliance.		
	The Routine Medications record indicated				Data will be reviewed by	the	
		started on the antibiotic,			CQI committee and if threshol		
	Bactrim, for ten	·			95% is not achieved an action		
	Bactilli, for tell	uays.			plan may be developed.		
	2 The climical m	ecord for Resident D was					
					What Date can the systemic		
		6/12 at 7:25 p.m. The			changes be completed?		
	record indicated				March 16, 2012		
		ing, but not limited to,					
		urogenic bladder, and					
	_	record indicated the					
	resident had a su	pra pubic urinary					
	catheter.						
	The resident's car	re plan, with "Problem					
	Start Date: 12/2/	11" indicated, "Resident					
	has hx [history o	f] chronic urinary tract					
	infection, urosep	sis 9/20/11 - neurogenic					
	bladder 9/20/11."						
	A physician's ord	der, dated 12/13/11					
	indicated, "UA C&S [urinalysis with						
	culture and sensitivity]. Pt [patient] C/O						
		ain in bladder area. If					
	OA neg [negative	e] send to [name of	I				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 00	COM	TE SURVEY PLETED 28/2012
	PROVIDER OR SUPPLIER		STR:	EET ADDRESS, CITY, STATE D FAIRWAY DR ANSVILLE, IN 47710	, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED T	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
TAG	resident's urological A physician's ord for Bactrim DS [twice daily for set [probiotic], 2 by days. Notation on the land sensitivity for 12/14/11, indicate notified of the resensitivity on 12/12. Escherichia colical 100,000 colony for "Confirmed ESB organismRecomonitoring of patherapy." Also constituity done was greater than 100, units. Nurse's notes, dap.m., indicated the new antibiotic, and indicated, "Ciproble BID [twice daily Nurse's notes, dap.m., indicated the resident was set of the resident was set of the resident was set of the set of the resident was set of th	der was received 12/15/12 antibiotic] 1 by mouth even days and Bacid mouth twice daily for 21 ab results of the culture following urinalysis on ed the physician was esults of the culture and forming urinalysis and L producing mmend caution and tients during/after ultured with no ever mixed skin flora of food colony forming ted 12/18/11 at 1:00 the physician ordered a forming p.o. [by mouth]	TAG	DEFICIES AND DEFIC	NCY)	DATE
	notified of the all	•				

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	of Correction identification number: 155148	A. BUILDING B. WING	00	COMPL 02/28/	ETED		
	PROVIDER OR SUPPLIER PARK NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	During Daily Exit on 2/27/12 at 3:00 p.m. the Director of Nursing Services (DNS) and Nurse Consultant were interviewed in regard to clarification as to what antibiotic was administered when pharmacy indicated the resident was allergic to Cipro. The Director of Nursing Services indicated she would locate the information. On 2/28/12 at 10:25 a.m., the Nurse Consultant provided copy of a Physician Telephone Order, dated 12/18/11 at 7:30 p.m., indicating to discontinue Cipro, discontinue prophylactic antibiotics (Bactrim), and discontinue Baccid. The Physician Telephone Order also indicated in the Care Plan Update section in the column for "Problem: does not warrant ATB [antibiotic] @ this X [time] AEB [as evidenced by] [symbol for negative] UTI." Documentation failed to indicate the resident was scheduled for an appointment with the urologist as indicated, if the resident did not have urinary tract infection, as ordered by the physician on the order of 12/13/11. During interview on 2/28/12 at 2:55 p.m., the Director of Health Services indicated an appointment was not scheduled with						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	00		E SURVEY LETED 3/2012	
NAME OF I	PROVIDER OR SUPPLIEF	1	STREET A	ADDRESS, CITY, STATE, ZIP CO	ODE	
NORTH PARK NURSING CENTER				VILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	_	ne indicated the resident ogist in January 2011.				
	Physical, dated 1 "presented to t Room] from his evaluation of a fi associated with I Workup in ER p patient was admi care unit] with the	al Admission History and 1/29/12, indicated, he ER [Emergency NH [nursing home] for ever of 104.1 which was hypotension in the ER. oint toward urosepsis and itted to ICU [intensive nat diagnosis." relates to Complaint				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING B. WING (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 02/28/2012					
	NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0465 SS=B	483.70(h) SAFE/FUNCTICABLE ENVIRON The facility must sanitary, and coresidents, staff at Based on observe facility failed to on the Faith Mea The deficient prategies of the facility. Findings included During observation Faith Meadow p.m., the floor we floor was soiled chart rack in the have dust and grashelf where chart During interview a.m., the Director (DNS) indicated move the Nurse' Meadows across hallways next to visible. She individually the she asked at the sale was across that the she asked at the sale was across that the she asked at the sale was across that the she asked at the sale was across that the she asked at the sale was across that the she asked at the sale was across that the she asked at the sale was across that the sale was across the sale was across that the sale was across that the sale was across that the sale was across the sale was across that the sale was across the sale was across the sale was across the sale was across that the sale was across the sale was across the sale was	DNAL/SANITARY/COMFORT of provide a safe, functional, infortable environment for and the public. In the public action and interview, the ensure the nurse's station adows unit was clean. In actice had the potential to desidents residing in the second in the Nurse's Station was unit 2/26/12 at 5:40 are gritty underfoot. The with gray scuffs. The stations was observed to ditty dirt on the bottom	F0465	F465 SAFE/FUNCTIONAL/ COMFORTABLE ENVIRONMENT The facility provides a safe, functional, sanitary and comfortable environment for residents, staff and the public. What corrective action(s) will be? accomplished for those residents found to have been affected by the deficient practice? No residents were identified in alleged deficient practice, How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take. No residents were identified the alleged deficient practice. All chart racks have been cleaned per housekeeping supervisor/designee complete 03/16/12.	03/16/2012 c. I I I I I I I I I I I I I I I I I I		
	see if the buffer	could come into the o clean the floor.		·Nurses station flooring approved for replacement on 03-1512.			

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AND PLAN OF CORRECTION IDENTIFY		IDENTIFICATION NUMBER: 155148		LDING	00	COMPLETED 02/28/2012	
NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	a.m., the DNS prindicated was rel flooring. During time, the Admini replacement of the Meadows Nurse's this year. Review provided indicated Corporation 2012 North Park Nursi signatures on the approval or dates installation of nethighlighter were: Nurses Station and Handwritten and handwritten from previous religioning room] - key During Initial Top.m., the Assistant provided a list of Review of the list lived on Faith Meadows Park Portion Provided and Park Portion Provided	documentation indicated of approval of the w flooring. Circled in typed messages: "New and Med Room - Station of Front Hall Flooring," message: "use flooring ferb [refurbishing] DR itchen small hallway." ur on 2/26/12 at 3:30 at Director of Nursing residents in the facility. t indicated 26 residents			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Housekeeping Supervisor/designee will monit through daily rounds to ensure chart racks are cleaned. Housekeeping supervisor/designee will report monthly results of daily rounds CQI committee. Maintenance Supervisor/Designee will monit the remodeling of Nurses station/flooring and report progress to CQI committee monthly. How the corrective action(s) will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. Data collected will be reviewed the CQI Committee. If threshoof 95% is not achieved, an act plan will be developed. What is the date by which the systemic changes will be completed? March 16, 2012	tor tite tor he ur, e? d by old ion	

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		IDENTIFICATION NUMBER: 155148	A. BUILDING B. WING	00	COMPLETED 02/28/2012
NAME OF P	ROVIDER OR SUPPLIER			NDDRESS, CITY, STATE, ZIP CODE RWAY DR	
	PARK NURSING CE		EVANS	VILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE

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Facility ID: 000069

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155148	B. WING 02/28/2012			
NAME OF B	DROVIDED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			650 FAI	IRWAY DR	
	NORTH PARK NURSING CENTER			EVANS	VILLE, IN 47710	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG F0514		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY	DATE
SS=D	483.75(I)(1) RES					
00 5		MPLETE/ACCURATE/ACCE				
	SSIBLE					
	1	maintain clinical records on				
		accordance with accepted ndards and practices that are				
		ately documented; readily				
		systematically organized.				
	The clinical reco	rd must contain sufficient				
		entify the resident; a record				
		assessments; the plan of				
	care and services provided; the results of any					
	State; and progr	reening conducted by the				
	i -	review and interview, the	F05	14		03/16/2012
		ensure documentation				
		the clinical record for 1 of			F514	
		e records were reviewed			Records-complete/accurate/a	ICC
		te documentation in a			essible This facility maintains clinical	
	sample of 4. (Re				records on each resident in	
	sample of 4. (Re	isident D)			accordance with accepted	
	Findings include				professional standards and	
	1 manigs merade	•			practices that are complete accurately documented; readil	v
	The clinical reco	ord for Resident D was			accessible; and systematically	•
		5/12 at 7:25 p.m. The			organized.	
	record indicated	*			What corrective action(s) will	
		e facility on 1/31/12 after			be?	1
		ed on 1/28/12. Diagnoses			accomplished for those	
	included, but we	· ·			residents found to have beer	ı
	quadriplegia.	• •			affected by the deficient	
	1 1 2				practice?	and
	A Nurse's Note	dated 2/17/12 at 10:00			 Resident D medication a treatment records are 	ilu
	· ·	'existing wound on			documented as per physician	
	1 1	as noted to be oozing			orders.	
	**	one nurse for [name of				
	l stood, so the plic	me marbe for [marile of			How will you identify other	l

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MI A. BUII B. WIN	LDING	onstruction 00	(X3) DATE S COMPLI 02/28/	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 650 FAIRWAY DR EVANSVILLE, IN 47710				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	order for Allevyropen area after c saline. Change e dislodgement. V Treatment Order 2012 indicated the onto the record. dates the treatment administered. N treatment was administered.				residents having the potential to be affected by the same deficient practice and what corrective action will be take. Residents who have medication/treatments administered have the potential be affected by the alleged deficient practice. Licensed Nurses were re-educated related to medication/treatment documentation by the DNS/designee on 3-8-2012.	n?	
	provided a copy Treatment Order 2012. Review of indicated the foll for "Allevyn gen area after cleanin Change every 3 of dislodgement:" the following dar	A box was drawn around tes: 2/17, 2/20, 2/23, and e's initial was indicated in			What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur? Nurse Manager's will observe one nurse weekly dura medication/treatment administration for medication/treatment documentation. The on-coming nurse wireview the MAR/TAR for completeness while giving rep. Nurse Managers will aud	ing II ort.	
	in regard to the r record, the DNS boxes around the treatment should She indicated wh Nurse Consultan	on 2/28/12 at 2:15 p.m. evised Treatment Order indicated she had drawn dates when the be been administered. hile she and the Corporate t were talking to the e for the dressing changes			the MAR/TAR weekly x 4 ther monthly x3 for compliance. How the corrective action(s) will be monitored to ensure t deficient practice will not reci.e., what quality assurance program will be put into place.	he eur,	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155148	A. BUILDING	CONSTRUCTION 00	(X3) DATE : COMPL 02/28/	ETED
	PROVIDER OR SUPPLIER		650 F	T ADDRESS, CITY, STATE, ZIP CODE AIRWAY DR	1	
NORTH PARK NURSING CENTER				ISVILLE, IN 47710		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG	about the lack of nurse filled in he interview at this? Nurse Consultant did not think the related to late ent Record. Both indexpect document fact to have indicted to have indicated the nurwanted to have indicated the nurwanted her to do boxes" around the Treatment On Resident D was interviewable resident.	documentation, the r initials. During time, the Corporate t and DNS indicated they facility had a policy tries on the Treatment dicated they would ation entered after the ration it was a late entry. The consultant indicated the nurse to enter the mass as the same time, the DNS are "thought it was what I a since I had drawn the e appropriate dates on deers form."	TAG	·A MAR/TAR audit will be completed weekly times for monthly x3 quarterly therea until compliance x2 by DNS/Designee. Data colle will be reviewed by the CQI Committee. If threshold of not achieved, an action plan be developed. What is the date by which systemic changes will be completed? March 16, 2012	r and fter ected 95% is n will	DATE
	related to his boy	e he encountered was vel regimen. Resident D supposed to receive a sist with bowel				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155148		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/28/2012	
	NAME OF PROVIDER OR SUPPLIER NORTH PARK NURSING CENTER			ADDRESS, CITY, STATE, ZIP CODE IRWAY DR SVILLE, IN 47710	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Wednesday, Fri Tuesday, Thursd indicated some suppository on others didn't. I record always sl suppository, wh do so. This federal tag	ry other day - Monday, day, then Sunday, day, Saturday. Resident D nurses always gave the the days ordered, and Resident D indicated the nowed the nurses gave the en he knew they did not relates to Complaint d Complaint IN00104314.			

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